State of Connecticut
Department of Developmental Services

Dannel P. Malloy
Governor

Terrence W. Macy, Ph.D.
Commissioner

Joseph W. Drexler, Esq.
Deputy Commissioner

DEPARTMENT OF DEVELOPMENTAL SERVICESS
REQUEST FOR CAPITAL IMPROVEMENT TO EXISTING
COMMUNITY LIVING ARRANGEMENTS

_____
DATE (A)

APPROVAL IS REQUESTED FOR THE CAPITAL IMPROVEMENT DETAILED BELOW AT:

_____

_____
Property Address (B)

Improvement Requested (C):

Description of Need (D):

Scope of Work (E):

Estimated Total Project Cost (F): $_____

Expense Incurred by: (check one) ☐ Provider ☐ CIL

Explanation of Cost Estimate (G):

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BID SUMMARY FORM

Provider: _____ Date: _____

Address: _____
_____

Project Location: _____ Number: _____

Description of Work: _____
_____
_____
_____
_____

Type of Contractor (General, Trade) _____

Contractors Requests to Submit Bids

	Date Received	Bid Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Contract Award To: _____

If exception to bidding process is requested, check reason:

__ Unable to solicit three bids __Urgency to complete work
__ Other: _____

If lowest bid is not selected, write justification for choice:
_____
_____
Remarks: _____

Prepared by: _____ Approved By: _____
Provider Region

REQUEST FOR CAPITAL IMPROVEMENTS TO EXISTING COMMUNITY LIVING ARRANGEMENTS (CONT'D)

Property Address: _____

_____
(H)

The undersigned acknowledge that this document does not constitute a contract for development of a property and further acknowledges that any payments by the State of Connecticut related to this property may only be made pursuant to Sections 17b-244 and 17a-228 of the General Statutes and the regulations promulgated thereunder.

PROPOSED BY:

Private Residential Provider

_____ _____
Signature (Name) (I) (Date)

_____
Print/Type Name

Tel No.: _____

PROPOSED BY:

Development Staff/Property Developer
(if Applicable)

_____ _____
Signature (Name) (J) (Date)

_____
Print/Type Name

Tel No. _____

REVIEWED BY:

_____ _____
Signature (Name) (L) (Date)
Regional Director for Region _____
Department of Developmental Services
(Or Authorized Designee)

_____
Print/Type Name

Tel No: _____

AFTER CONSULTATION WITH:

_____ _____
(Signature) (Name) (M) (Date)
Commissioner
Department of Social Services
(Or Authorized Designee)

APPROVED BY

_____ _____
(Signature) (Name) (N) (Date)
Commissioner
Department of Developmental Services
(Or Authorized Designee)